MDR Tracking Number: M5-04-0675-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on November 3, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, joint mobilization, myofascial release, electrical stimulation, office visit (established patient), hot/cold pack therapy and special reports were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 04-07-03 to 07-18-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 13th day of January 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

January 9, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-0675-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement.

The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 39 year-old male who sustained a work related injury to his lower back on ___ while lifting. He was treated with physical therapy from 7/17/01 to 8/31/01. A MRI of the lumbar spine performed on 7/25/01 revealed disc degeneration and minimal annular bulge/ herniation at L5-S1 and shallow left lateral herniation at L4-5. On 11/16/01, this patient saw a chiropractor and was diagnosed with rule out lumbar disc herniation, lumbar radiculopathy, thoracic sprain/strain, myofascitis and sacroiliac joint disorder. On 3/8/02, he was diagnosed with lumbar radiculopathy, lumbar facet syndrome, sacroiliac joint dysfunction, myofascial pain syndrome and insomnia secondary to chronic pain. He underwent epidural steroid injections on 4/22/02, 5/20/03 and 7/15/02. On 8/13/03, he was diagnosed with disc herniation with left S1 radiculopathy and continued severe back pain. A discogram performed on 9/24/03 revealed L4-5 and L5-S1 concordant pain and posterior tears. On 12/3/02, the patient underwent a posterior fusion of L4-S1 with instrumentation and Brantigan Cages, right and left lumbar hemilaminectomy, foraminotomy and nerve root decompression of L4-S1. He started post-operative rehabilitation on 4/7/03. This patient has been treated with medications, physical therapy, chiropractic treatment and epidural steroid injections.

Requested Services

Office visits, therapeutic exercises, joint mobilization, myofascial release, electrical stimulation, office visit (established patient), hot/cold pack therapy, and special reports from 4/7/03 to 7/18/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 39 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that diagnoses for this patient has included disc degeneration and minimal annular bulge/herniation at the L5-S1 levels. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included medications, physical therapy, chiropractic treatment, epidural steroid injections and a posterior fusion of L4-S1 with instrumentation and Brantigan Cages on 12/3/02. The ___ chiropractor reviewer indicated that prior to surgery the patient underwent treatment with the treating chiropractor and that this treatment was not beneficial to the patient. The ___ chiropractor reviewer explained that based on the outcome of the preoperative treatment, the patient would have benefited more by following the surgeons prescribed treatment. Therefore, the ___ chiropractor consultant concluded that that office visits, therapeutic exercises, joint mobilization, myofascial release, electrical stimulation, office visit (established patient), hot/cold pack therapy, and special reports from 4/7/03 to 7/18/03 were not medically necessary to treat this patient's condition.

Sincerely,